SKYVIEW VETERINARY HOSPITAL

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Dr. Heather Austin

AAHA ACCREDITED
The Standard of Veterinary Excellence

Thank you for giving us the opportunity to care for your pet. Please help us better meet your needs by taking a few moments to fill out all pages of this information sheet.

Owner's Name:_____ Cellphone # _____
Spouse/Other:_____ Cellphone# _____

Driver's License #: _____

Address: _____ City: _____ State: _____
Zip: _____ Home Phone #: _____

Email: _____

Employer's Name: _____

Work Phone #: _____

If Military: Active: ___ Retired ____ **Senior Discount (65 or older):** Yes: ____ No:____

DUE TO STATE LAW AND INSURANCE REQUIREMENTS, ALL DOGS & CATS MUST BE CURRENT ON RABIES VACCINATION. Vaccination can be updated at the time of your appointment if it is not current.

I understand every effort will be made to achieve a successful outcome and to provide for all possible safety in hospital care and handling. I hereby authorize this hospital to receive, prescribe for, treat or perform surgery upon the pet(s) listed on the reverse side and additional pets I present.

I agree to pay fees for services rendered at the time the pet is discharged from the hospital or the service is otherwise terminated. By signing below, I acknowledge that I will be responsible for any interest and collection fees should my account be referred to a collection agency due to non-payment. I also understand that if legal action is required to collect any unpaid balance that I may be held responsible for any reasonable attorneys fees that may be incurred. I understand that a service fee of $30.00 will be assessed for each non-sufficient fund check and/or certified letter that must be sent.

If I neglect to pick up my pet within 5 days of the discharge date and do not contact Skyview Veterinary Hospital to make alternative arrangements, my pet will be considered abandoned, at which point Skyview Veterinary Hospital will re-home the pet. I will still be financially liable for costs incurred prior to the date the animal is considered abandon.

Signature:_____ **Date**:_____

Please fill out back page....

In Case of EMERGENCY, Call _____ At Phone #_____

We will gladly prepare a written estimate if you so desire. Please ask a receptionist or doctor. Professional fees are due at time services are rendered. If you wish to pay by check or credit card, please complete the following.

How did you hear of our hospital?

( ) Individual, Someone We May Thank with a $25 referral credit to their account?

_____

( ) Social Media?

( ) Internet Search?

( ) Other, please state: _____

Animal Medical History

Please complete information for all your pets - Thank You!	Pet #1	Pet #2	Pet #3
Pet's Name			
Species (Dog, Cat, Bird, etc.)			
Breed			
Description (Color and Markings)			
Age or Date of Birth (Approximate)			
Sex	( ) M ( ) F	( ) M ( ) F	( ) M ( ) F
Neutered or Spayed?	( ) Y ( ) N	( ) Y ( ) N	( ) Y ( ) N
Diet (Name of Your Pet's Food)			
Daily Medications, Vitamins or Treats			
Shampoo/Flea Products Used Heartworm Prevention			